UTAH ACCIDENT & HEALTH SURVEY INSTRUCTIONS

All Fraternal, Health, Life and Property & Casualty insurers in Utah who report accident and health business on the Utah State page of the NAIC Annual Statement are required to complete and file this annual survey. All other insurers are exempt. The completed survey form should be sent to the Utah Insurance Department **by April 1, 2011**. All submissions should be made via email to jhawley@utah.gov. Hard copies (paper filings) are no longer acceptable. Failure to file by the deadline may subject your company to the enforcement penalties under Utah Code Annotated § 31A-2-308. Any questions on completing this survey form should be directed to Jeff Hawley, Research Analyst via email to jhawley@utah.gov (Phone: (801) 538-9684, Fax: (801) 538-3829).

This survey is designed to collect accident and health data in greater detail than is reported on the Utah State page of the NAIC Annual Statement. The survey follows definitions and categories used in the NAIC Annual Statement as much as possible. All data values reported on the survey form should represent the year-end totals of the report year (December 31, 2010) and be consistent with the Utah specific data reported on the NAIC Annual Statement for 2010.

Please note that direct insured business means business where the insurance company bears the underwriting risk prior to ceding or assumption and should include all Utah residents (even if your company wrote the policy in another state and the insured member later moved into Utah). If your company did not report any direct accident and health insurance business in Utah (i.e., zero reported for direct accident and health business in Utah on the Utah State page), then your company is exempt from filing the survey form.

The survey form is divided into thirteen major parts:

In part 1, companies report detailed information regarding all of the fully insured accident health business in Utah during 2010. The information reported here should balance to the Utah State page of NAIC Annual Statement as of Dec. 31, 2010.

In part 2, companies report the various lines of accident & health business that were being actively marketed in Utah during 2010.

In part 3, companies with Medicare product business in Utah report detailed membership data for Medicare Supplement, Medicare Advantage (Part C), and Medicare Drug Plan (Part D) plans. The information reported here should balance to the information reported in part 1.

In part 4, companies with Long-Term Care business in Utah report additional detail and membership data for their Long-Term Care plans. The information reported here should balance to the information reported in part 1.

In part 5-A, companies report membership and claim data for administrative services of self-funded health benefit plans.

In part 5-B, companies report additional detail for certain types of administrative services. This category was created for a select number of companies with special circumstances. Most companies will not need to use this category.

In part 6, all health insurers or Health Maintenance Organizations licensed under the Utah State Insurance Code shall file annually with the Utah Insurance Department a list of all value-added benefits offered at no cost to its enrollees. Submit a copy of your company's list of value-added benefits along with the survey.

In part 7, companies with Comprehensive Hospital & Medical business provide additional detail regarding Traditional Defined Benefit Plans and Utah Health Exchange Benefit Plans. The information reported here should balance to the information reported in part 1. Companies that do not have any Comprehensive Hospital & Medical business may ignore parts 7 through 13.

In parts 8-10, companies with Traditional Defined Benefit Plans, including the new "Mandate Lite" Plans. The information reported here should balance to the information reported in part 7, and be internally consistent.

In parts 11-13, companies with Utah Health Exchange Plans, including the new "Mandate Lite" Plans. The information reported here should balance to the information reported in part 7 and be internally consistent. Companies that do not offer plans on the Utah Health Exchange may ignore parts 11 through 13.

SIGNATURE FORM

The last component of the survey is the Signature Form. As of December 31, 2007, the Utah Accident & Health Survey includes a business confidentiality signature form. The Utah Insurance Department collects the Utah Accident & Health Survey with the intent and understanding that these records are classified as protected records under U.C.A. § 63G-2-305(2). The Signature Form is being made available from the website along with the instructions and form. The Signature Form should be filed along with the survey. This signature form ensures that the data is properly classified as a protected record under U.C.A. § 63G-2-305(2). In order to ensure this data is properly classified, please sign and date the Signature Form and return it to the Utah Insurance Department. This year's form covers data your company may have sent to the Utah Insurance Department during 1999 to 2010.

A version of this signature form will be a standard part of the annual Utah Accident & Health Survey going forward. Any member of your company can sign the form, so your signature would be fine. Please sign the form and send an electronic copy (e.g., Adobe PDF format), along with the survey form, via email to Jeff Hawley (jhawley@utah.gov). A copy will be kept on file along with your survey.

PART I: UTAH INSURED ACCIDENT & HEALTH BUSINESS

COLUMN DEFINITIONS

NUMBER OF INSURED MEMBERS:	For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of certificate holders plus dependents.
NUMBER OF INSURED POLICIES:	For individual policies, enter the number of insured policyholders. For group policies, enter the number of certificate holders.
DIRECT PREMIUMS WRITTEN:	Enter the total premiums collected for policies written during the report year for each A&H insurance category.
DIRECT PREMIUMS EARNED:	Enter the portion of premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year for each A&H insurance category.
DIRECT LOSSES PAID:	Enter the actual amount of losses paid by the insurer during the report year for each A&H insurance category.
DIRECT LOSSES INCURRED:	Enter the total amount of losses incurred by the insurer during the report year for each A&H insurance category.

ROW DEFINITIONS

COMPREHENSIVE HOSPITAL & MEDICAL:	Business that includes major medical, comprehensive medical and other hospital-surgical-medical benefit plans designed to be the insured member's primary health benefit plan. This category includes H16 Major Medical health benefit plans filed via SERFF as H16I, H16G, HOrg02I, or HOrg02G, as well as H15 Hospital, Medical, Surgical expense plans that are designed to function as substitute for a primary health benefit plan (e.g., H15 Hospital, Medical, Surgical expense plan (Substitute)). Exclude all H15 Hospital, Medical, Surgical expense plans that are designed to function as a supplement to a primary health benefit plan (see Hosp-Med-Surgical (Supplement Only)). If Comprehensive Hospital & Medical is reported, parts 7-13 must also be completed (see Comprehensive Hospital & Medical Supplement).
HOSP-MED-SURGICAL (SUPPLEMENT ONLY):	Business that include any hospital only expense, medical only expense, surgical only expense, hospital and medical expense, hospital and surgical expense, medical and surgical expense, and hospital, medical and surgical expense (supplement). This category includes H15I or H15G Hospital, Medical, Surgical expense plans that are designed to function as a supplement to a primary health benefit plan (e.g., H16 Major Medical or H15 Hospital, Medical, Surgical expense (Substitute)). Exclude all H16 Major Medical health benefit plans and H15 Hospital, Medical, Surgical expense (Substitute) plans. This category replaces the "MEDICAL ONLY" category used in previous surveys.
MEDICARE SUPPLEMENT:	Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. Includes all standardized and pre-standardized plans that are sold as a supplement to Medicare Part A and Part B. These plans serve only as a supplement to Medicare and do not cover the full cost of Medicare subscribers. Exclude all Medicare Advantage policies. If Medicare Supplement is reported, parts 3-A and 3 -B must also be completed.
MEDICARE ADVANTAGE (PART C):	Policies that qualify as Medicare Part C plans. Includes all full replacement policies that cover the full medical cost of Medicare subscribers. These plans are not sold as a supplement to Medicare, but are sold as a full replacement of Medicare coverage and provide additional benefits including pharmacy, hospital, and medical coverage beyond what Medicare typically covers. Exclude all Medicare Supplement policies. In the past, these plans have been reported under Title XVIII Medicare (see Title XVIII Medicare) or under Medicare Supplement (see Medicare Supplement). For the purposes of this survey, all Medicare Advantage polices are to be reported as a separate, unique product. If Medicare Advantage is reported, parts 3-C and 3-D must also be completed.
MEDICARE DRUG PLAN (PART D):	Policies that qualify as Medicare Part D plans. Includes all stand-alone pharmacy products that provide coverage for Medicare Part D, as well as plans that provide additional drug benefits beyond the minimum requirements for Medicare Part D. Exclude all Medicare Supplement and Medicare Advantage policies. If Medicare Part D is reported, part 3-E must also be completed.

DENTAL ONLY:	Policies providing for dental only coverage issued as a stand alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
VISION ONLY:	Policies providing for vision only coverage issued as stand alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
FEDERAL EMPLOYEES (FEHBP):	Business allocable to the Federal Employees Health Benefit Plan premium.
Title XVIII MEDICARE:	Business where a premium is collected and the insurer covers the full medical costs of Medicare subscribers. Includes all specialized coverage that covers the full medical costs of Medicare subscribers, except for Medicare Advantage plans. Although Medicare Advantage plans technically qualify under this category, for the purposes of this survey, Medicare Advantage plans should be excluded from this section. Instead, report all Medicare Advantage plans under "Medicare Advantage" (see Medicare Advantage for details).
Title XIX MEDICAID:	Business where a premium is collected and the insurer covers the full medical costs of Medicaid subscribers.
STOP LOSS:	Stop loss insurance coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product.
DISABILITY INCOME:	Policies providing coverage for loss of income resulting from a disability.
LONG-TERM CARE:	Business allocable to Long-Term Care coverage. If Long-Term Care is reported, parts 4-A and 4-B must also be completed.
CREDIT A&H:	Policies providing for credit disability insurance. Excludes credit unemployment, credit life, and credit property insurance.
ALL OTHER A&H:	Other coverage not specifically addressed in any of the other categories.
TOTAL ACCIDENT AND HEALTH:	Sum total of all of the A&H categories listed previously. This line (line 16, part I) must balance with the total accident and health premium and losses reported on the Utah State page of the Annual Statement.

PART 2: MARKETING OF ACCIDENT & HEALTH BUSINESS

In addition to reporting the accident & health business your company had in Utah during 2010, please note that your company must also provide information on the specific lines of accident & health business your company marketed in Utah during 2010.

PART 2: MARKETING OF INSURED ACCIDENT & HEALTH BUSINESS IN UTAH

COMPREHENSIVE HOSPITAL & MEDICAL:	Selling a policy that includes major medical, comprehensive medical and other hospital, medical, surgical expense plans designed to be the insured member's primary health benefit plan.
HOSP-MED-SURGICAL: (SUPPLEMENT ONLY)	Selling hospital, medical, medical expense plans such as hospital only, medical only, surgical only, which are designed as a supplement to a primary health benefit plan.
MEDICARE SUPPLEMENT: (AGE 0 to 64):	Selling Medicare Supplement policies that would be reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. Selling to people age 64 and younger.
MEDICARE SUPPLEMENT (AGE 65 and older):	Selling Medicare Supplement policies that would be reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. Selling to people age 65 and older.
MEDICARE ADVANTAGE (PART C) (AGE 0 to 64):	Selling Medicare Advantage policies that qualify as Medicare Part C plans, and act as full replacement policies for Medicare, i.e., covers the full cost of Medicare subscribers in exchange for a premium. Insurance Experience Exhibit of the annual statement. Selling to people age 64 and younger.
MEDICARE ADVANTAGE (PART C) (AGE 0 and older):	Selling Medicare Advantage policies that qualify as Medicare Part C plans, and act as full replacement policies for Medicare, i.e., covers the full cost of Medicare subscribers in exchange for a premium. Insurance Experience Exhibit of the annual statement. Selling to people age 65 and older.
MEDICARE DRUG PLAN (PART D):	Selling policies providing stand-alone pharmacy only coverage that qualifies as a Medicare Part D plan.
DENTAL ONLY:	Selling policies providing for dental only coverage issued as a stand alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
VISION ONLY:	Selling policies providing for vision only coverage issued as stand alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.
STOP LOSS:	Selling stop loss insurance coverage for a self-insured group plan, a provider/provider group or non-proportional reinsurance of a medical insurance product.
DISABILITY INCOME:	Selling policies providing coverage for loss of income resulting from a disability.
LONG-TERM CARE:	Selling policies that provide Long-Term Care coverage.
CREDIT A&H:	Selling policies providing for credit disability insurance. Excludes credit unemployment, credit life, and credit property insurance.
ALL OTHER A&H:	Selling accident & health coverage not specifically addressed in any of the other categories.
COMPANY NOT SELLING A&H:	If your company is ***not*** actively selling any form of accident & health insurance (e.g., all previous categories are “NO”), enter “YES” in this category. Otherwise enter “NO”.

PART 3: MEDICARE PRODUCT BUSINESS

This section provides additional detail on Medicare Product business in Utah. If your company reports Medicare Supplement business in line 3, part I; Medicare Advantage business in line 4, part I; or Medicare Part D business in line 5, part I, then your company must complete this section.

PART 3I-A: AGE STATISTICS FOR MEDICARE SUPPLEMENT BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Medicare Supplement coverage and divide the members by age. To calculate each member's age, start with all of the members that were enrolled in a Medicare Supplement plan in Utah as of December 31, 2010. There should be the same number of members that were reported in line 3, column 1, part 1. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2010. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2010). Use the calculated age in years for each member to classify the membership into the following categories.

COLUMN CATEGORIES

NUMBER OF INSURED MEMBERS:	The total number of members with Medicare Supplement coverage. Lines 1 and 2 should total to line 3. The total number of members reported here should balance to the number of insured members reported in line 3, column 1, part 1.

ROW CATEGORIES

Age 0-64	Members age 64 and younger.
Age 65 and older	Members age 65 and older.
Total Members	Total members regardless of age. Lines 1 and 2 should total to line 3 (this category). The total number of members reported here should balance to the number of insured members reported in line 3, column 1, part 1.

PART 3-B: MEDICARE SUPPLEMENT MEMBERSHIP IN UTAH BY PLAN TYPE

To complete this section, take the total membership in Utah with Medicare Supplement coverage as of December 31, 2010 and classify the members by the standardized Medicare Supplement plans listed on the survey form. The total number of members reported here should balance to the number of insured members reported in line 3, column 1, part 1.

PART 3-C: AGE STATISTICS FOR MEDICARE ADVANTAGE (PART C) BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Medicare Advantage (Part C) coverage and divide the members by age. To calculate each member's age, start with all of the members that were enrolled in a Medicare Advantage (Part C) plan in Utah as of December 31, 2010. There should be the same number of members that were reported in line 4, column 1, part 1. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2010. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2010). Use the calculated age in years for each member to classify the membership into the following categories.

COLUMN CATEGORIES

NUMBER OF INSURED MEMBERS:	The total number of members with Medicare Advantage (Part C) coverage. Lines 1 and 2 should total to line 3. The total number of members reported here should balance to the number of insured members reported in line 4, column 1, part 1.

ROW CATEGORIES

Age 0-64	Members age 64 and younger.
Age 65 and older	Members age 85 and older.
Total Members	Total members regardless of age. Lines 1 and 2 should total to line 3 (this category). The total number of members reported here should balance to the number of insured members reported in line 4, column 1, part I.

PART 3-D: MEDICARE ADVANTAGE (PART C) MEMBERSHIP IN UTAH BY PLAN TYPE

To complete this section, take the total membership in Utah with Medicare Advantage (Part C) coverage as of December 31, 2010 and classify the members by the standardized Medicare Advantage (Part C) plans listed on the survey form. The total number of members reported here should balance to the number of insured members reported in line 4, column 1, part 1.

PART 3-E: AGE AND GENDER STATISTICS FOR MEDICARE DRUG PLAN (PART D) BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Medicare Drug Plan (Part D) coverage and divide the members by age and gender. To calculate each member's age, start with all of the members that were enrolled in a Medicare Drug Plan (Part D) in Utah as of December 31, 2010. There should be the same number of members that were reported in line 5, column 1, part 1. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2010. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2010). Use the calculated age in years for each member to classify the membership into the following categories.

COLUMN CATEGORIES

NUMBER OF INSURED MEMBERS:	The total number of members with Medicare Drug Plan (Part D) coverage. Lines 1 and 2 should total to line 3. The number of male and female members should equal the total number of members. The total number of members reported here should balance to the number of insured members reported in line 5, column 1, part 1.

ROW CATEGORIES

Age 0-64	Members age 64 and younger.
Age 65 and older	Members age 65 and older.
Total Members	Total members regardless of age. Lines 1 and 2 should total to line 3 (this category). The total number of members reported here should balance to the number of insured members reported in line 5, column 1, part 1.

PART 4: LONG-TERM CARE BUSINESS

This section provides additional detail on Long-Term Care business in Utah. If your company reports Long Term Care business in line 13, part 1, then your company must complete this section.

PART 4-A: UTAH INSURED LONG TERM CARE BUSINESS ONLY

COLUMN DEFINITIONS

NUMBER OF INSURED MEMBERS:	For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of certificate holders plus dependents.
NUMBER OF INSURED POLICIES:	For individual policies, enter the number of insured policyholders. For group policies, enter the number of certificate holders.
DIRECT PREMIUMS WRITTEN:	Enter the total premiums collected for policies written during the report year.
DIRECT PREMIUMS EARNED:	Enter the portion of premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year.
DIRECT LOSSES PAID:	Enter the actual amount of losses paid by the insurer during the report year.
DIRECT LOSSES INCURRED:	Enter the total amount of losses incurred by the insurer during the report year.

ROW DEFNITIONS

INDIVIDUAL:	Long-Term Care policies issued to an individual person.
GROUP (2 or more):	Long-Term Care policies issued to a group organization.
TOTAL:	Sum total of individual and group Long-Term Care policies.

PART 4-B: AGE AND GENDER STATISTICS FOR LONG-TERM CARE BUSINESS IN UTAH

To complete this section, take the total membership in Utah with Long-Term Care coverage and divide the members by age and gender. To calculate each member's age, start with all of the members that were enrolled in a Long-Term Care plan in Utah as of December 31, 2010. There should be the same number of members that were reported in line 13, column 1, part I. Use the member's date of birth to determine the age of the member (in years) as of December 31, 2010. Most database software currently in use has a function that will count the number of years between two dates (e.g., between the date of birth and December 31, 2010). Use the calculated age in years for each member to classify the membership into the following categories.

COLUMN CATEGORIES

NUMBER OF INSURED MEMBERS:	The total number of members with Long-Term Care coverage. Lines 1 through 7 should total to line 8. The total number of members reported here should balance to the number of insured members reported in line 13, column 1, part I.

ROW CATEGORIES

Age 0-59	Members age 59 and younger.
Age 60-64	Members between the ages of 60 to 64.
Age 65-69	Members between the ages of 65 to 69.
Age 70-74	Members between the ages of 70 to 74.
Age 75-79	Members between the ages of 75 to 79.
Age 80-84	Members between the ages of 80 to 84.
Age 85 and older	Members age 85 and older.
Total Members	Total members regardless of age. Lines 1 through 7 (the previous 7 categories) should total to line 8 (this category). The total number of members reported here should balance to the number of insured members reported in line 13, column 1, part I.

PART 5-A: ADMINISTRATIVE SERVICES FOR UTAH SELF-FUNDED HEALTH BENEFIT PLANS

SELF-FUNDED MEDICAL PLANS:	This category refers to any administrative business (third party administration, administrative services only, or administrative services contract) with a self-funded or ERISA eligible employer-sponsored medical plan in the State of Utah.

COLUMN DEFINITIONS

NUMBER OF MEMBERS:	Enter the total number of members in self-funded health benefit plans administered by the insurer.
ADMIN. INCOME:	Enter the total dollar amount of administrative income received by the insurer for administrating self-funded health benefit plans.
CLAIM ACTIVITY:	Enter the total dollar amount of claims processed by the insurer while administrating self-funded or insured medical plans.

ROW DEFINITIONS

(See “Plan Categories” in the Comprehensive Hospital & Medical Supplement”)

PART 5-B: ADMINISTRATIVE SERVICES FOR FEHBP, MEDICARE, AND MEDICAID BUSINESS

You should only complete this section if your company provides administrative services only (ASO), administrative services contracts (ASC) and other non-underwritten administrative business related to the Federal Employee Health Benefit Plan (FEHBP), Utah Medicaid, Federal Medicare programs, or other type of administrative services that the Utah Insurance Department needs additional information on. Exclude all business reported under self-funded health benefit plans. All data should be current as of December 31, 2010. Most companies who need this category have already been instructed to use it. If you have questions on whether you should use this category, contact Jeff Hawley.

PART 6: VALUE-ADDED BENEFITS (see Utah Code Annotated (U.C.A.) 31A-8a-207)

All health insurers or Health Maintenance Organizations licensed under the Utah State Insurance Code shall file annually with the Utah Insurance Department a list of all value-added benefits offered at no cost to its enrollees. Please submit a copy of your company’s list of value-added benefits along with this survey.

PARTS 7-13: COMPREHENSIVE HOSPITAL & MEDICAL SUPPLEMENT

This section provides additional detail on Comprehensive Hospital & Medical business in Utah. If your company reports Comprehensive Hospital & Medical business in line 1, part 1, then your company must complete part 7 and then, depending on the nature of your business you may also need to complete additional tables in parts 8 through 13.

COLUMN DEFINITIONS

NUMBER OF INSURED MEMBERS:	For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of certificate holders plus dependents.
CUMULATIVE MEMBER MONTHS:	Enter the cumulative year-end member months for each comprehensive hospital & medical plan category. If you report comprehensive premium, you must report member months, even if the insured members is zero at the end of the calendar year. To calculate member months, first count the number of insured members during each month of the year. This produces 12 member counts (one for each month). Then sum total all 12 member counts. This total is the cumulative member months for the year. For example, if your company had 10 insured members during each of the 12 months of the year, the cumulative member months would be calculated as follows: 10 members x 12 months = 120 member months.
DIRECT PREMIUMS WRITTEN:	Enter the total premiums collected for policies written during the report year.
DIRECT PREMIUMS EARNED:	Enter the portion of premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year.
DIRECT LOSSES PAID:	Enter the actual amount of losses paid by the insurer during the report.
DIRECT LOSSES INCURRED:	Enter the total amount of losses incurred by the insurer during the report year.
NUMBER OF INSURED EMPLOYERS:	Enter the total number of insured employers for each row category. This category in used in Part 11 only. "Number of Insured Employers" means a count of the number of small employers with a defined contribution plan sold through the Utah Health Exchange for each network structure type. Please note that column 7 may not necessarily add up to the total number of employers covered through the Utah Health Exchange. For example, if a single small employer (1) had a FFS plan (line 1.1), a PPO plan (line 1.2), a HMO plan (line 1.3), and a HMO-POS plan (line 1.4) through the Utah Health Change, the total number of insured employers in line 1.6 would still be one (1), not four (4), because there is still only one employer being covered even though the employer has four separate health benefit plans. The unit of analysis is the employer, not the benefit plan.

ROW DEFINTIONS

TRADITIONAL DEFINED BENEFIT PLANS:	Traditional Defined Benefit Plans are Comprehensive Hospital & Medical Plans filed for use under Utah's standard regulatory rules and are not eligible for sale within the Utah Health Exchange. Most plans currently in existence qualify under this definition.
UTAH HEALTH EXCHANGE PLANS:	Utah Health Exchange Plans are specialized Comprehensive Hospital & Health Plans filed for use under the specialized regulatory rules of the Utah Health Exchange marketplace. These plans can only be sold through the Utah Health Exchange and are not sold in the Traditional Defined Benefit marketplace. Your company must be registered with the Utah Health Exchange to sell these plans.

Group Categories

INDIVIDUAL & CONVERSION:	Insured policies issued to an individual person. This now includes individual conversion policies that have been converted from a group insured policy.
SMALL GROUP (2 to 50):	Uses HIPPA definition of small group size. Insured policies issued to a group organization.
LARGE GROUP (51 or more):	Uses HIPPA definition of large group size. Insured policies issued to a group organization.
TOTAL:	Total of Individual & Conversion, Small Group, and Large Group Comprehensive Hospital & Medical.

COMPREHENSIVE HOSPITAL & MEDICAL SUPPLEMENT (CONTINUED)

Plan Categories

INDEMNITY / FEE FOR SERVICE PLAN (FFS):	Under a Traditional Indemnity or Fee For Service plan (FFS), the insured member can use any provider they choose (as long as the services are a covered benefit under the insurance plan). There are no preferred provider networks and all services are reimbursed at the same cost sharing level (usually a fixed percentage of billed charges) regardless of which provider they choose. The insured member usually has a fixed coinsurance rate above the deductible. Only licensed Accident & Health insurers can offer FFS plans in Utah. However, if the FFS plan includes a PPO rider that allows individuals to pay a lower co-payment or coinsurance rate when they visit doctors or obtain medical services from a network of preferred providers, then the plan should be classified as a PPO for the purposes of the survey (see "Preferred Provider Organization Plan (PPO):").
PREFERRED PROVIDER ORGANIZATION PLAN (PPO):	Under a Preferred Provider Organization plan (PPO), the insured member has lower deductibles and coinsurance if they use physicians or hospitals in the preferred provider network. PPOs cannot limit members to the preferred provider network only, as this would be an EPO arrangement and PPOs are prohibited from doing this under Utah code. Rather, members have a financial incentive to stay within the preferred provider network, as costs are lower if they use preferred providers. Members are free to use any provider outside the network, but services are reimbursed at a lower rate and typically members must pay higher costs to do so. Only licensed Accident & Health insurers can offer PPO plans in Utah. In the past, if the PPO plan required permission from a primary physician or gatekeeper, or required some other form of pre-authorization prior to receiving services from a non-preferred provider that is outside of the network, then the plan was classified as a PPO with POS features for the purposes of the survey (see "Preferred Provider Organization Plan with Point of Service Features (PPO w / POS features):"). However, as of 2010, all PPO with POS feature plans are now classified as PPOs. Do not put PPO with POS feature plans in "Other", classify them as "PPO".
PREFERRED PROVIDER ORGANIZATION PLAN WITH POINT OF SERVICE FEATURES (PPO w / POS features):	Previous special category for certain types of PPOs. In the past, this category was used if the PPO plan required permission from a primary physician or gatekeeper, or required some other form of pre-authorization prior to receiving services from a non-preferred (PPO provider that is outside of the network).):"). However, as of 2010, all PPO with POS feature plans are now classified as PPOs. Do not put PPO with POS feature plans in "Other", classify them as "PPO". See also "Preferred Provider Organization Plan (PPO):"
HEALTH MAINTENANCE ORGANIZATION PLAN (HMO):	Under a Health Maintenance Organization plan (HMO), the member must use the HMO network providers exclusively, except in the case of an emergency. No services provided outside of the HMO network are covered. Only licensed HMOs can offer HMO plans in Utah. However, if the HMO plan has a point-of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers), then the plan should be classified as HMO with POS features for the purposes of the survey.
HEALTH MAINTENANCE ORGANIZATION PLAN WITH POINT OF SERVICE FEATURES (HMO w / POS features):	Special category for certain types of HMOs. Use this category if the HMO plan has a point-of-service, indemnity carve out, out-of-network rider, or other option where members may use providers who are outside of the HMO network for routine medical services (not emergencies), but at a lower reimbursement rate (e.g., costs the member more to use non-network providers). See also "Health Maintenance Organization Plan (HMO):"
OTHER PLANS:	Use the all other category for plans that do not fit into any of the previous categories. If this category is used, you should include a brief description of the plan features and explain why the other categories are not applicable. PPO with POS features plans should not go in this category, put them in the PPO category. This category should not be used at all in most cases, as comprehensive hospital and medical plans filed for use in Utah should qualify for one the other categories.

COMPREHENSIVE HOSPITAL & MEDICAL SUPPLEMENT (CONTINUED)

Product Categories

Standard FFS, PPO, HMO, and HMO-POS:	These are standard health benefit plans that have been traditionally sold in Utah. These plans do not omit mandates or adjust benefits to create specialized insurance products described by specific statutes under the Utah Insurance Code. Exclude Federally Qualified HDHP plans, Utah NETCARE plans, and any "Mandate Lite" plans.
"MANDATE LITE" PLANS:	Any plan under the Utah Insurance Code that is allowed to omit one or more of Utah's health insurance mandates. These plans include FFS Lite, FFS Mandate Lite, FFS NETCARE (Mandate Lite), PPO Lite, PPO Mandate Lite, PPO NETCARE (Mandate Lite), HMO Lite, HMO Mandate Lite, HMO NETCARE (Mandate Lite), HMO-POS Lite, HMO-POS Mandate Lite, and HMO-POS NETCARE (Mandate Lite).
FFS and PPO LITE:	This is new term of art for a new type of "Mandate Lite" plan in the non-Chapter 8 market. These plans are available in the Individual, Small Group, and Large Group Markets, and may exclude "Non-discrimination of providers and Health Insurance Mandates created after January 1, 2009". See Utah Code Annotated 31A-22.618.5.
HMO and HMO-POS LITE:	This is new term of art for a new type of "Mandate Lite" plan in the Chapter 8 (HMO) market. These plans are available in the Individual, Small Group, and Large Group Markets, and may exclude "Indemnity Benefits, Point of Service, Basic Health Care Services, and Health Insurance Mandates created after January 1, 2009". See Utah Code Annotated 31A-22.618.5.
FFS and PPO MANDATE LITE:	This a new term of art for a new type of "Mandate Lite" plan in the Chapter 30 (Individual and Small Group) market. These plans are available in the Individual and Small Group Markets, and may exclude "Tiered Contracted Providers, Non-Discrimination of Providers, Health Insurance Mandates created after January 1, 2009, the Adoption Indemnity Benefit mandate (U.C.A. 31A-22-610.1), the Inborn Metabolic Errors mandate (U.C.A. 31A-22-623), Primary Care Physician (U.C.A. 31A-22-624), the Diabetes mandate (U.C.A. 31A-22-626), and Specialist Referral (U.C.A. 31A-22-628)". See Utah Code Annotated 31A-30-109(1-2).
HMO and HMO-POS MANDATE LITE:	This a new term of art for a new type of "Mandate Lite" plan in the Chapter 30 (Individual and Small Group) market. These plans are available in the Individual and Small Group Markets, and may exclude "Tiered Contracted Providers, Non-Discrimination of Providers, Health Insurance Mandates created after January 1, 2009, the Adoption Indemnity Benefit mandate (U.C.A. 31A-22-610.1), the Inborn Metabolic Errors mandate (U.C.A. 31A-22-623), Primary Care Physician (U.C.A. 31A-22-624), the Diabetes mandate (U.C.A. 31A-22-626), and Specialist Referral (U.C.A. 31A-22-628)". See Utah Code Annotated 31A-30-109(1-2).
FFS, PPO, HMO, and HMO-POS Federally Qualified HDHP:	Any High Deductive Health Plan that qualifies as a Federally Qualified High Deductible Health Plan and is eligible for use with a Health Savings Account (HSA). Exclude any plan that is not a HSA eligible health plan (e.g., All traditional health plans).
FFS, PPO, HMO, and HMO-POS NETCARE (Standard)	This is a new alternative plan for COBRA, mini-COBRA, and Conversion. See Utah Code Annotated 31A-22-724(2).
FFS, PPO, HMO, and HMO-POS NETCARE (Mandate Lite)	This is the "Mandate Lite" version of the new NETCARE plans. These plans may exclude "Health Insurance Mandates created after January 1, 2009, the Adoption Indemnity Benefit mandate (U.C.A. 31A-22-610.1), the Inborn Metabolic Errors mandate (U.C.A. 31A-22-623), Primary Care Physician (U.C.A. 31A-22-624), the Diabetes mandate (U.C.A. 31A-22-626), and Specialist Referral (U.C.A. 31A-22-628)". See Utah Code Annotated 31A-22-724(2).